BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Consolidated Matter of the Accusations Against: Farhad Bagha Nowzari, M.D. Physician's and Surgeon's Certificate No. A 71464 Respondent.	Case Nos.: 800-2016-019595 and 800-2018-048232

DECISION

The attached Stipulated Settlement and Disciplinary Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on March 17, 2023.

IT IS SO ORDERED: February 17, 2023.

MEDICAL BOARD OF CALIFORNIA

Richard E. Thorp, M.D., Chair
Panel B

ROB BONTA
Attorney General of California
EDWARD KIM
Supervising Deputy Attorney General
BRIAN D. BILL
Deputy Attorney General
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Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Consolidated Matter of the Accusations Against: **FARHAD BAGHA NOWZARI, M.D.** **1349 Via Coronel** **Palos Verdes Estate, CA 90274** **Physician's and Surgeon's Certificate No. A 71464,** Respondent.	Case No. 800-2016-019595 and Case No. 800-2018-048232 OAH No. 2020090350 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

PARTIES

1. William Prasifka (Complainant) is the Executive Director of the Medical Board of California (Board). He brought this action solely in his official capacity and is represented in this matter by Rob Bonta, Attorney General of the State of California, by Brian D. Bill, Deputy Attorney General.

2. Respondent Farhad Bagha Nowzari, M.D. (Respondent) is represented in this proceeding by attorney Raymond J. McMahon, whose address is: 5440 Trabuco Road Irvine, CA 92620.

3. On or about April 28, 2000, the Board issued Physician's and Surgeon's

Certificate No. A 71464 to Respondent. The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation Nos. 800-2016-019595 and 800-2018-048232, and will expire on September 30, 2023, unless renewed.

JURISDICTION

4. Accusation Nos. 800-2016-019595 and 800-2018-048232 were filed before the Board, and are currently pending against Respondent. Accusation Nos. 800-2016-019595 and 800-2018-048232 and all other statutorily required documents thereto were properly served on Respondent on January 3, 2019, and September 9, 2021, respectively. Respondent timely filed a Notice of Defense in each matter contesting the Accusations. On December 15, 2021, the Presiding Administrative Law Judge Matthew Goldsby of the Office of Administrative Hearings, consolidated Accusation Nos. 800-2016-019595 and 800-2018-048232, with the former (9595) deemed the lead case.

5. Copies of Accusation Nos. 800-2016-019595 and 800-2018-048232 are attached as Exhibits A and B, respectively, and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation Nos. 800-2016-019595 and 800-2018-048232. Respondent has also carefully read, fully discussed with his counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

7. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusations; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

8. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

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CULPABILITY

9. Respondent understands and agrees that the charges and allegations in Accusation Nos. 800-2016-019595 and 800-2018-048232, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

10. Respondent agrees that, at a hearing, Complainant could establish a prima facie case or factual basis for the charges in Accusation Nos. 800-2016-019595 and 800-2018-048232, and that Respondent hereby gives up his right to contest those charges.

11. Respondent does not contest that, at an administrative hearing, complainant could establish a prima facie case with respect to the charges and allegations in Accusation Nos. 800-2016-019595 and 800-2018-048232, a true and correct copy of each are attached hereto as Exhibits A and B, respectively, and that he has thereby subjected his Physician's and Surgeon's Certificate, No. A 71464 to disciplinary action.

12. Respondent agrees that his Physician's and Surgeon's Certificate is subject to discipline and he agrees to be bound by the Board's probationary terms as set forth in the Disciplinary Order below.

RESERVATION

13. The admissions made by Respondent herein are only for the purposes of this proceeding, or any other proceedings in which the Medical Board of California or other professional licensing agency is involved, and shall not be admissible in any other criminal or civil proceeding.

CONTINGENCY

14. This stipulation shall be subject to approval by the Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or his counsel. By signing the stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary

Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

15. Respondent agrees that if he ever petitions for early termination or modification of probation, or if an accusation and/or petition to revoke probation is filed against him before the Board, all of the charges and allegations contained in Accusation Nos. 800-2016-019595 and 800-2018-048232 shall be deemed true, correct and fully admitted by respondent for purposes of any such proceeding or any other licensing proceeding involving Respondent in the State of California.

16. This Stipulated Settlement and Disciplinary Order is intended by the parties herein to be an integrated writing representing the complete, final and exclusive embodiment of the agreement of the parties in this above entitled matter.

17. The parties understand and agree that Portable Document Format (PDF) and facsimile copies of this Stipulated Settlement and Disciplinary Order, including PDF and facsimile signatures thereto, shall have the same force and effect as the originals.

18. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or opportunity to be heard by the Respondent, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 71464 issued to Respondent FARHAD BAGHA NOWZARI, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for six (6) years on the following terms and conditions:

1. EDUCATION COURSE. Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The

educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

2. MEDICAL RECORD KEEPING COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

3. PSYCHIATRIC EVALUATION. During the period between executing this stipulation and the effective date of this Decision, but in no case later than 30 calendar days of the effective date of this Decision, and on whatever periodic basis thereafter may be required by the Board or its designee, Respondent shall undergo and complete a psychiatric evaluation (and psychological testing, if deemed necessary) by a board-certified psychiatrist who shall consider any information provided by the Board or designee and any other information the psychiatrist

deems relevant, and shall furnish a written evaluation report to the Board or its designee. An evaluating psychiatrist shall have no prior or current business or personal relationship with Respondent, or other relationship that could reasonably be expected to compromise the ability of the evaluating psychiatrist to render fair and unbiased reports to the Board, including but not limited to any form of bartering. Respondent shall pay the cost of all psychiatric evaluations and psychological testing.

Respondent shall comply with all restrictions or conditions recommended by the evaluating psychiatrist no later than 15 calendar days after being notified by the Board or its designee.

Respondent shall not perform any surgical procedures until notified by the Board or its designee that Respondent is mentally fit to perform surgical procedures safely. If Respondent is deemed not mentally fit to perform surgical procedures, Respondent shall immediately cease all practice of medicine and shall not engage in the practice of medicine until notified in writing by the Board or its designee of its determination that Respondent is mentally fit to practice safely. The period of time that Respondent is not practicing medicine shall not be counted toward completion of the term of probation.

4. MEDICAL EVALUATION AND TREATMENT. During the period between executing this stipulation and the effective date of this Decision, but in no case later than 30 calendar days of the effective date of this Decision, and on whatever periodic basis thereafter may be required by the Board or its designee, Respondent shall undergo and complete a medical evaluation by a physician who shall consider any information provided by the Board or designee and any other information the evaluating physician deems relevant and shall furnish a medical report to the Board or its designee. An evaluating physician shall have no prior or current business or personal relationship with Respondent, or other relationship that could reasonably be expected to compromise the ability of the evaluating physician to render fair and unbiased reports to the Board, including but not limited to any form of bartering. Respondent shall provide the evaluating physician with any information and documentation that the evaluating physician may deem pertinent.

Following the evaluation, Respondent shall comply with all restrictions or conditions

recommended by the evaluating physician within 15 calendar days after being notified by the Board or its designee. If Respondent is required by the Board or its designee to undergo medical treatment, Respondent shall within 30 calendar days of the requirement notice, submit to the Board or its designee for prior approval the name and qualifications of a California licensed treating physician of Respondent's choice. Upon approval of the treating physician, Respondent shall within 15 calendar days undertake medical treatment and shall continue such treatment until further notice from the Board or its designee.

The treating physician shall consider any information provided by the Board or its designee or any other information the treating physician may deem pertinent prior to commencement of treatment. Respondent shall have the treating physician submit quarterly reports to the Board or its designee indicating whether or not the Respondent is capable of practicing medicine safely. Respondent shall provide the Board or its designee with any and all medical records pertaining to treatment that the Board or its designee deems necessary.

If, prior to the completion of probation, Respondent is found to be physically incapable of resuming the practice of medicine without restrictions, the Board shall retain continuing jurisdiction over Respondent's license and the period of probation shall be extended until the Board determines that Respondent is physically capable of resuming the practice of medicine without restrictions. Respondent shall pay the cost of the medical evaluation(s) and treatment.

Respondent shall not perform any surgical procedures until notified by the Board or its designee that Respondent is physically fit to perform surgical procedures safely. If Respondent is deemed not physically fit to perform surgical procedures, Respondent shall immediately cease all practice of medicine and shall not engage in the practice of medicine until notified in writing by the Board or its designee of its determination that Respondent is physically fit to practice safely. The period of time that Respondent is not practicing medicine shall not be counted toward completion of the term of probation.

5. PROCTORING. Respondent shall successfully complete at least ten (10) non-robotic urological surgeries proctored by physicians and surgeons whose licenses are valid and in good standing, and who are board-certified by the American Board of Urology. All proctors shall have

no prior or current business or personal relationship with Respondent, or other relationship that could reasonably be expected to compromise the ability of the proctor to render fair and unbiased proctoring report, including but not limited to any form of bartering. Respondent shall pay all proctoring costs, if any. Within 30 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval as the proctor(s) under this condition, the name and qualifications of one or more licensed physicians and surgeons. At the completion of the (10) non-robotic urological surgeries pursuant to this section, the proctor(s) will submit a report(s) to the Board or its designee which unequivocally states whether Respondent has demonstrated the ability to safely and independently perform non-robotic urological surgeries. Respondent shall not perform non-robotic urological surgeries without a proctor until Respondent has successfully completed all ten (10) of the proctored cases required by this condition and Respondent's proctors have so notified by the Board or its designee in writing.

Based on Respondent's performance during the proctored cases, the proctor(s) will also advise the Board or its designee of its recommendation(s), if any, for any additional education, clinical training and/or further evaluation as may be necessary to ensure Respondent's safe practice as a urological surgeon. Respondent shall comply with the proctors' recommendations.

6. MONITORING - PRACTICE. Within 30 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval as a practice monitor, the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with Respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in Respondent's field of practice, and must agree to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision(s) and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the

Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusation(s), fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, Respondent's medical practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If Respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor(s) shall submit a quarterly written report to the Board or its designee which includes an evaluation of Respondent's performance, indicating whether Respondent's practices are within the standards of practice of medicine, and whether Respondent is practicing medicine safely. It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a

replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, Respondent may participate in a professional enhancement program approved in advance by the Board or its designee that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at Respondent's expense during the term of probation.

7. PROHIBITED PRACTICE. During probation, Respondent is prohibited from performing all robotic surgical procedures. After the effective date of this Decision, all patients being treated by the Respondent shall be notified that the Respondent is prohibited from performing all robotic surgical procedures. Any new patients must be provided this notification at the time of their initial appointment.

Respondent shall maintain a log of all patients to whom the required oral notification was made. The log shall contain the: 1) patient's name, address and phone number; 2) patient's medical record number, if available; 3) the full name of the person making the notification; 4) the date the notification was made; and 5) a description of the notification given. Respondent shall keep this log in a separate file or ledger, in chronological order, shall make the log available for immediate inspection and copying on the premises at all times during business hours by the Board or its designee, and shall retain the log for the entire term of probation.

8. NOTIFICATION. Within seven (7) days of the effective date of this Decision, the Respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

9. SUPERVISION OF PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE

NURSES. During probation, Respondent is prohibited from supervising physician assistants and advanced practice nurses.

10. OBEY ALL LAWS. Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

11. INVESTIGATION/ENFORCEMENT COST RECOVERY. Respondent is hereby ordered to reimburse the Board its costs of investigation and enforcement, in the amount of $27,017.50 (twenty-seven thousand seventeen dollars and fifty cents). Costs shall be payable to the Medical Board of California. Failure to pay such costs shall be considered a violation of probation.

Payment must be made in full within 30 calendar days of the effective date of the Order, or by a payment plan approved by the Medical Board of California. Any and all requests for a payment plan shall be submitted in writing by respondent to the Board. Failure to comply with the payment plan shall be considered a violation of probation.

The filing of bankruptcy by respondent shall not relieve respondent of the responsibility to repay investigation and enforcement costs.

12. QUARTERLY DECLARATIONS. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

13. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

Address Changes

Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no

circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021, subdivision (b).

Place of Practice

Respondent shall not engage in the practice of medicine in Respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal

Respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside California

Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

In the event Respondent should leave the State of California to reside or to practice Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

14. INTERVIEW WITH THE BOARD OR ITS DESIGNEE. Respondent shall be available in person upon request for interviews either at Respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

15. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is defined as any period of time Respondent is not practicing medicine as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If Respondent resides in California and is considered to be in non-practice, Respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-

practice and does not relieve Respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event Respondent's period of non-practice while on probation exceeds 18 calendar months, Respondent shall successfully complete the Federation of State Medical Boards's Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two (2) years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice for a Respondent residing outside of California will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; Quarterly Declarations; Abstain from the Use of Alcohol and/or Controlled Substances; and Biological Fluid Testing..

16. COMPLETION OF PROBATION. Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. This term does not include cost recovery, which is due within 30 calendar days of the effective date of the Order, or by a payment plan approved by the Medical Board and timely satisfied. Upon successful completion of probation, Respondent's certificate shall be fully restored.

17. VIOLATION OF PROBATION. Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Board shall have

continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

18. LICENSE SURRENDER. Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender his or her license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall within 15 calendar days deliver Respondent's wallet and wall certificate to the Board or its designee and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

19. PROBATION MONITORING COSTS. Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

20. FUTURE ADMISSIONS CLAUSE. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing action agency in the State of California, all of the charges and allegations contained in Accusation Nos. 800-2016-019595 and 800-2018-048232 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict license.

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ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Raymond J. McMahon. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 9/29/2022

FARHAD BAGHA NOWZARI, M.D.
Respondent

I have read and fully discussed with Respondent Farhad Bagha Nowzari, M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: September 29, 2022

RAYMOND J. MCMAHON
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California.

DATED: _____

Respectfully submitted,

ROB BONTA
Attorney General of California
EDWARD KIM
Supervising Deputy Attorney General

BRIAN D. BILL
Deputy Attorney General
Attorneys for Complainant

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ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Raymond J. McMahon. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: _____

FARHAD BAGHA NOWZARI, M.D.
Respondent

I have read and fully discussed with Respondent Farhad Bagha Nowzari, M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: _____

RAYMOND J. MCMAHON
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California.

DATED: September 29, 2022

Respectfully submitted,

ROB BONTA
Attorney General of California
EDWARD KIM
Supervising Deputy Attorney General

Brian D. Bill

BRIAN D. BILL
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2016-019595

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Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **Farhad Bagha Nowzari, M.D.** **1349 Via Coronel** **Palos Verdes Estates, CA 90274** **Physician's and Surgeon's Certificate No. A 71464,** Respondent.	Case No. 800-2016-019595 **ACCUSATION**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about April 28, 2000, the Board issued Physician's and Surgeon's Certificate Number A 71464 to Farhad Bagha Nowzari, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on September 30, 2019, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2234 of the Code, states:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"...

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"..."

5. Section 2228 of the Code states:

"The authority of the board or the California Board of Podiatric Medicine to discipline a licensee by placing him or her on probation includes, but is not limited to, the following:

"(a) Requiring the licensee to obtain additional professional training and to pass an examination upon the completion of the training. The examination may be written or oral, or both, and may be a practical or clinical examination, or both, at the option of the board or the administrative law judge.

"(b) Requiring the licensee to submit to a complete diagnostic examination by one or more

physicians and surgeons appointed by the board. If an examination is ordered, the board shall receive and consider any other report of a complete diagnostic examination given by one or more physicians and surgeons of the licensee's choice.

"(c) Restricting or limiting the extent, scope, or type of practice of the licensee, including requiring notice to applicable patients that the licensee is unable to perform the indicated treatment, where appropriate.

"(d) Providing the option of alternative community service in cases other than violations relating to quality of care."

6. Section 805 states:

"(a) As used in this section, the following terms have the following definitions:

"(1) Peer review body includes:

"(A) A medical or professional staff of any health care facility or clinic licensed under Division 2 (commencing with Section 1200) of the Health and Safety Code or of a facility certified to participate in the federal Medicare Program as an ambulatory surgical center.

"...

"(2) Licentiate means a physician and surgeon, doctor of podiatric medicine, clinical psychologist, marriage and family therapist, clinical social worker, or dentist. Licentiate also includes a person authorized to practice medicine pursuant to Section 2113.

"(3) Agency means the relevant state licensing agency having regulatory jurisdiction over the licentiates listed in paragraph (2).

"(4) Staff privileges means any arrangement under which a licentiate is allowed to practice in or provide care for patients in a health facility. Those arrangements shall include, but are not limited to, full staff privileges, active staff privileges, limited staff privileges, auxiliary staff privileges, provisional staff privileges, temporary staff privileges, courtesy staff privileges, locum tenens arrangements, and contractual arrangements to provide professional services, including, but not limited to, arrangements to provide outpatient services.

"(5) Denial or termination of staff privileges, membership, or employment includes failure or refusal to renew a contract or to renew, extend, or reestablish any staff privileges, if the action

is based on medical disciplinary cause or reason.

"(6) Medical disciplinary cause or reason means that aspect of a licentiate's competence or professional conduct that is reasonably likely to be detrimental to patient safety or to the delivery of patient care.

"(7) 805 report means the written report required under subdivision (b).

"(b) The chief of staff of a medical or professional staff or other chief executive officer, medical director, or administrator of any peer review body and the chief executive officer or administrator of any licensed health care facility or clinic shall file an 805 report with the relevant agency within 15 days after the effective date of any of the following that occur as a result of an action of a peer review body:

"...

"(3) Restrictions are imposed, or voluntarily accepted, on staff privileges, membership, or employment for a cumulative total of 30 days or more for any 12-month period, for a medical disciplinary cause or reason.

"(c) The chief of staff of a medical or professional staff or other chief executive officer, medical director, or administrator of any peer review body and the chief executive officer or administrator of any licensed health care facility or clinic shall file an 805 report with the relevant agency within 15 days after any of the following occur after notice of either an impending investigation or the denial or rejection of the application for a medical disciplinary cause or reason:

"(1) Resignation or leave of absence from membership, staff, or employment.

"(2) The withdrawal or abandonment of a licentiate's application for staff privileges or membership.

"(3) The request for renewal of those privileges or membership is withdrawn or abandoned.

"(d) For purposes of filing an 805 report, the signature of at least one of the individuals indicated in subdivision (b) or (c) on the completed form shall constitute compliance with the requirement to file the report.

"(e) An 805 report shall also be filed within 15 days following the imposition of summary

suspension of staff privileges, membership, or employment, if the summary suspension remains in effect for a period in excess of 14 days.

"(f) A copy of the 805 report, and a notice advising the licentiate of his or her right to submit additional statements or other information pursuant to Section 800, shall be sent by the peer review body to the licentiate named in the report.

"The information to be reported in an 805 report shall include the name and license number of the licentiate involved, a description of the facts and circumstances of the medical disciplinary cause or reason, and any other relevant information deemed appropriate by the reporter.

"A supplemental report shall also be made within 30 days following the date the licentiate is deemed to have satisfied any terms, conditions, or sanctions imposed as disciplinary action by the reporting peer review body. In performing its dissemination functions required by Section 805.5, the agency shall include a copy of a supplemental report, if any, whenever it furnishes a copy of the original 805 report.

"If another peer review body is required to file an 805 report, a health care service plan is not required to file a separate report with respect to action attributable to the same medical disciplinary cause or reason. If the Medical Board of California or a licensing agency of another state revokes or suspends, without a stay, the license of a physician and surgeon, a peer review body is not required to file an 805 report when it takes an action as a result of the revocation or suspension.

"..."

FACTUAL ASSERTIONS

7. Patient No. 1[1] was a 78-year-old female with a history of dementia and urolithiasis.[2] Patient No. 1 presented to the emergency department at Providence Little Company of Mary Torrance Hospital (Hospital) on July 9, 2015, with altered mental status (AMS).

a. Respondent previously performed two urologic procedures on Patient No. 1: a

[1] Patient numbers are used in lieu of names to protect privacy.

[2] The process of forming stones in the kidney, bladder, and/or urethra; a common cause of blood in the urine and pain in the abdomen, flank, or groin.

ureteral stent placement[3] on December 31, 2014, and bilateral ureteroscopy[4] (revealing bilateral ureteral strictures[5]); and ureteral stent exchange on May 7, 2015, for acute infection.

8. On July 9, 2015, Patient No. 1 was transferred to the Hospital by way of ambulance from the nursing home where she resided.

a. Hospital emergency department providers noted Patient No. 1 to be "listless," with mild tachycardia[6] (a heart rate of 101 beats per minute (BPM)), and a low blood pressure of 116/53. Patient No. 1's labs were severely abnormal which indicated acute renal failure.

b. Patient No. 1's objective signs were consistent with sepsis[7] due to a urinary tract (UTI) infection.

c. A Foley catheter was placed, however, there was no urine output. Patient No. 1 was given IV fluids and antibiotics.

d. Patient No. 1 progressively became hypotensive[8] and was given a vasoconstrictor[9] as an intervention.

e. The Hospital's critical care team was consulted and expressed concern regarding possible infected stents. An ultrasound of Patient No. 1's abdomen revealed ureteral stents in place with bilateral hydronephrosis,[10] which indicated stent obstruction.

f. Patient No. 1's treating physician, Dr. V.P., determined the patient was in septic shock due to a UTI with likely infected stents, and acute kidney injury with bilateral hydronephrosis.

g. Patient No. 1's condition soon deteriorated and she became hypotensive in fulminant septic shock.[11]

h. Patient No. 1's blood pressure was temporarily stabilized, she began to produce

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[3] A thin tube that's placed in the ureter to help drain urine from the kidney.
[4] It is a procedure in which a small scope is inserted into the bladder and ureter, used to diagnose and treat a variety of problems in the urinary tract.
[5] An obstruction or narrowing of the ureter.
[6] an abnormally rapid heart rate
[7] A life-threatening illness caused by the body's response to an infection.
[8] Abnormally low blood pressure.
[9] A drug that increases blood pressure.
[10] Swelling of a kidney due to a build-up of urine caused by a blockage or obstruction.
[11] Severe and sudden in onset of the symptom.

some urine, and the hypokalemia resolved. However, Patient No. 1's lactate level increased,[12] she remained uremic,[13] and her white blood cell count increased as a result of the infection. As such, based upon the various lab tests and objective signs and symptoms, Patient No. 1's condition continued to deteriorate.

i. Dr. V.P. ordered a urology consult on July 10, 2015, at approximately 12:55 a.m. At that time, Dr. V.P. personally discussed Patient No. 1's case with Respondent.

j. Respondent made no effort to evaluate Patient No. 1 in person on either July 10, 2015, or July 11, 2015.

k. Respondent finally evaluated Patient No. 1 in person on July 12, 2015, at 9:00 a.m. Respondent's first in-person consultation occurred approximately 57 hours after the initial telephone consultation with Dr. V.P. Respondent's consult note of July 12, 2015, documented that Patient No. 1's urine culture revealed bacteria and was still septic. Respondent further noted that he planned to exchange the stents "in the next few days."

l. Patient No. 1 was eventually taken to the operating room on July 16, 2015. Patient No. 1's operation occurred four days after Respondent's in-person consultation with Respondent, and seven days after Patient No. 1's admission to the Hospital.

m. Respondent performed a bilateral ureteroscopy,[14] a stent exchange, and a retrograde pyelogram.[15] Respondent noted "high-grade stricture"[16] with a "string deformity,"[17] and persistent bilateral hydronephrosis. Respondent also noted that Respondent was "much improved since previous study [May 7, 2015 procedure], probably due to stents."

n. During the bilateral ureteroscopy, Respondent was unable to pass the scope through the left ureter. However, the scope successfully passed through the right ureter and into the kidney. The procedure lasted 1.5 hours.

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[12] An increase in lactic acid level in blood indicates a worsening of an infection.
[13] A dangerous condition that occurs when the kidneys no longer filter properly.
[14] A procedure wherein a flexible scope is inserted into the bladder by way of the ureter.
[15] Imaging test that uses X-rays to view bladder, ureters, and kidneys.
[16] A urethral stricture is scarring in or around the urethra that narrows or blocks the passageway through which urine flows from the bladder.
[17] A permanent structural deviation from the normal shape, size, or alignment, resulting in disfigurement; may be congenital or acquired.

o. In the recovery room, the nurse observed Patient No. 1 to be tachycardic,[18] shaking, and sweating excessively. Each of the post-surgical observations are consistent with sepsis.

p. On July 17, 2015, one day after the surgery, Patient No. 1 was observed to be bradycardic[19] (approximately 60 BPM), agonal breathing,[20] and a non-detectible pulse. The observations are further consistent with sepsis.

q. Patient No. 1 then went into cardiac asystole[21] and expired.

9. The standard of care regarding optimal timing for evaluation and intervention of the acutely ill patient with urosepsis requires the following:

a. Personally evaluate the patient immediately to discover the cause of urosepsis, determine the stability of the patient, and recommend intervention; and

b. Promptly initiate the treatment plan to rescue the patient from progressive septic shock.

c. In general, consultation with an acutely sick patient should occur immediately.

d. In patients with blockage of the urinary tract due to nonfunctional stents or an impacted ureteral stone, drainage of the obstruction should be done as soon as possible, typically within 4-6 hours, to prevent worsening sepsis.

10. Respondent's failure to timely evaluate and treat Patient No. 1 constitutes a departure from the standard of care:

a. Respondent was consulted urgently by the critical care team due to severe sepsis from urinary tract obstruction. Respondent did not evaluate Patient No. 1 in person until 57 hours after the initial consultation, a profound delay. This delay constitutes a departure from the standard of care.

b. Respondent then delayed an additional 4 days before he performed a surgical intervention, a second profound delay. This delay constitutes a departure from the standard of

[18] An abnormally rapid heart rate.
[19] A slow heart rate.
[20] An abnormal pattern of breathing and brainstem reflex characterized by gasping, labored breathing, accompanied by strange vocalizations and involuntary muscle contraction.
[21] Cardiac arrest rhythm with no discernible electrical activity on the EKG monitor.

care.

11. Standard of Care regarding optimal drainage of an obstructed urinary system:

a. A patient with known ureteral strictures with a recent stent placement, who presented with recurrent severe urosepsis and hydronephrosis must undergo immediate drainage of the urinary tract.

b. The standard of care requires at a minimum, exchange of stents. However, placement of percutaneous nephrostomy tubes[22] (PCNT) is particularly favored in such a patient due to a lower anesthesia requirement and less manipulation of an infected system.

12. Respondent's care and treatment deviated from the standard of care as to the choice of procedure to drain Patient No. 1's obstructed urinary system.

a. Respondent previously performed a ureteroscopy with stent exchange on Patient No. 1 on May 7, 2015. During that procedure, Respondent documented ureteral strictures with purulence.

b. When Patient No. 1 presented again with sepsis on July 9, 2015, it was apparent that the ureteral stents were again obstructed. At the time of consultation, Respondent knew the stents had failed in an unusually short period of time. Respondent could have recommended placement of PCNTs by interventional radiology, which would have been the preferred approach given Patient No. 1's recent stent procedure. Repeating the same failed management is to be avoided.

c. During a subsequent interview with the Board, Respondent claimed he elected to proceed with the ureteroscopy and stent exchange because Patient No. 1's family requested the approach.

d. Respondent's poor choice in management constitutes a departure from the standard of care.

13. The standard of care regarding intraoperative management of infected stents requires that obstructed stents to be immediately removed or exchanged.

[22] A thin plastic tube that is passed from the back, through the skin and then through the kidney. PCNTs are designed to temporarily drain the blocked urine. This allows the kidneys to function properly and prevents further damage.

a. This procedure should be performed during surgery as quickly as possible with a minimum amount of manipulation and instrumentation of the urinary tract, to avoid worsening of sepsis.

b. Performing ureteroscopy should never be done in a patient with urosepsis as it will exacerbate infection due to pyelovenous backflow[23] and worsening bacteremia.[24] Performing a ureteroscopy in such a patient can disturb the bacteria, which can spread bacteria. Thus, exacerbating the sepsis.

14. Respondent's intraoperative management of Patient No. 1's infected stents departed from the standard of care. Given Patient No. 1's recent ureteroscopy and worsening septic condition, Respondent's choice to perform a ureteroscopy constitutes a departure from the standard of care.

a. There was no diagnostic or therapeutic reason to perform a second ureteroscopy in two months.

b. A stent replacement should be done as quickly as possible with minimum manipulation of the urinary tract. An average stent exchange should take about 10 minutes. This case took 1.5 hours.

c. The decision to perform ureteroscopy was a major factor contributing to Patient No. 1's death shortly thereafter. Whereas a stent exchange alone may have resolved the UTI and sepsis.

PATIENT NO. 2

15. Patient No. 2 was 67-year-old a female with Turner's syndrome,[25] and a prior hysterectomy. Patient No. 2 was 4'5" tall and weighed 99 pounds.

16. On November 19, 2015, Respondent performed a robot assisted, left radical nephrectomy[26] surgery on Patient No. 2. to remove a suspected cancerous mass.

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[23] Drainage of fluid in the opposite direction - from the renal pelvis of a kidney into the renal venous system.

[24] The presence of bacteria in the blood.

[25] A chromosomal condition that affects development in females. The most common feature of Turner syndrome is short stature.

[26] Surgical removal of one or both of the kidneys.

a. Respondent noted that Patient No. 2's small statute and severe scoliosis resulted in "significantly difficult anatomy." Further Respondent noted multiple atypical vessels leading to the left kidney, resulted in distorted vascular and perirenal[27] anatomy.

b. During the surgery, Respondent encountered difficulty with vascular control. During ligation[28] of one of the atypical arterial vessels, Respondent noted that the vessel was not controlled completely as the vascular stapler device malfunctioned. The stapler device cut the vessel but did not apply staples. As a result, the vessel began to bleed. However, the bleeding was eventually controlled with laparoscopic clip applier.

c. Respondent then opted to convert the surgery to an open procedure. The main renal artery and vein were tied and divided. Other aberrant vessels which were also ligated.

d. During surgery, Patient No. 2 received one unit of blood.

e The surgery lasted six hours, during which Patient No. 2 experienced multiple episodes of hypotension.[29]

f. During surgery, the anesthesiologist responded to multiple "sharps drops" in blood pressure, episodes of hemodynamic instability,[30] and bleeding that caused hypotension.

g. The anesthesiologist repeatedly alerted Respondent as to Patient No. 2's deteriorating condition and repeatedly recommended that Respondent devise a surgical plan that would expedite the surgery and prevent further bleeding episodes.

h. Near the conclusion of the surgery, Patient No. 2 experienced another bleeding episode. As a result, Patient No. 2 was kept intubated post-operatively, overnight.

17. On November 20, 2015, one-day post-surgery, Patient No. 2 was observed to have cold bilateral lower extremities with an absent pulse.

a. An arterial doppler[31] of Patient No. 2's lower extremities revealed blocked arterial blood flow.

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[27] Tissues surrounding the kidneys.
[28] Tie or otherwise close off an artery or vessel.
[29] Abnormally low blood pressure.
[30] Unstable blood movement throughout the body.
[31] A test that uses high-frequency sound waves to measure the amount of blood flow through the arteries and veins.

b. A Computed Tomography (CT) Angiogram[32] revealed the aorta was blocked with "an overlying or adjacent surgical clip."

c. Patient No. 2 was then evaluated by a cardiologist who suspected arterial thrombosis.

d. Interventional cardiology recommended and attempted a minimally invasive intervention. However, the procedure was unsuccessful.

e. During the procedure, the cardiologist called Respondent to discuss the surgical issues that took place to determine if there was some mechanical obstruction/constriction of the aorta. Respondent commented that there was a "possibility" of suturing and/or stapling the aorta during the nephrectomy.

f. The cardiologist then discussed the matter with a vascular surgeon. The consensus was Patient No. 2 likely would not benefit from open aortic repair due to irreversible ischemia.[33]

18. On November 21, 2015, Patient No. 2 died.

19. The standard of care when performing a radical nephrectomy requires the surgeon to perform the following steps:

a. Review preoperative imaging to develop a detailed surgical plan that compensates for unusual or variant anatomy;

b. Proper placement of robotic ports in relation to the kidney;

c. Mobilization of the left colon to expose the kidney;

d. Identification of the gonadal vein and ureter; and

e. Identification and isolation of the left renal artery and vein before deploying a laparoscopic stapler or vascular clips.

20. Respondent's performance of the nephrectomy departed from the standard of care as Respondent failed to properly identify the left renal artery, instead erroneously transected the aorta. Respondent failed to employ any other techniques to assist with proper vascular

[32] An imaging test that examines the blood vessels and tissues using contrast dye.
[33] An inadequate blood supply to an organ or part of the body.

identification

21. The standard of care in recognizing catastrophic complications during or immediately after surgery requires:

a. Immediate recognition of the complication by the operating surgeon and rectify the complication by seeking help.

b. A major vascular injury warrants immediate consultation with vascular surgery.

c. The proper response to surgical complications is the responsibility of the surgeon.

22. Respondent's lack of recognition of the catastrophic complications that occurred during Patient No. 2's surgery is a departure from the standard of care.

a. Respondent failed to recognize the aortic transection during the surgery, a catastrophic complication.

b. Respondent should have identified the existence of a complication during the surgery due to:

1. Patient No. 2's atypical vascular anatomy,

2. Major bleeding that occurred during surgery;

3. Documented malfunction of the stapler; and/or

4. When the anesthesiologist repeatedly informed Respondent that Patient No. 2 was hypotensive and required an intraoperative blood transfusion.

c. Respondent should have identified the existence of a complication post-surgery when Patient No. 2 remained intubated.

23. On or about January 7, 2016, pursuant to California Business and Professions Code section 805, the Hospital reported to the Board that Respondent voluntarily resigned his console robotic surgery privileges. Respondent's resignation of his robotic surgery privileges was, in part, due to his care and treatment of Patient Nos. 1 and 2.

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FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

24. Respondent Farhad Bagha Nowzari, M.D. is subject to disciplinary action under California Business and Professions Code section 2234, subdivision (b), in that Respondent's care and treatment of Patient Nos. 1 and 2 constitutes gross negligence. The circumstances are as follows:

25. The facts and circumstanced alleged in paragraphs 7 through 23 above, are incorporated by reference as if set forth in full herein.

SECOND CAUSE FOR DISCIPLINE

(Repeated Acts of Negligence)

26. Respondent Farhad Bagha Nowzari, M.D. is subject to disciplinary action under California Business and Professions Code section 2234, subdivision (c), in that Respondent's care and treatment of Patient Nos. 1 and 2 constitutes repeated acts of negligence. The circumstances are as follows:

27. The facts and circumstanced alleged in paragraphs 7 through 23 above, are incorporated by reference as if set forth in full herein.

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PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 71464, issued to Farhad Bagha Nowzari, M.D.;

2. Revoking, suspending or denying approval of Farhad Bagha Nowzari, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Farhad Bagha Nowzari, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED:

January 3, 2019

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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Exhibit B

Accusation No. 800-2018-048232

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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **FARHAD BAGHA NOWZARI, M.D.** **1349 Via Coronel** **Palos Verdes Estates, CA 90274** **Physician's and Surgeon's Certificate** **A 71464,** Respondent.	Case No. 800-2018-048232 **ACCUSATION**

PARTIES

1. William Prasifka (Complainant) brings this Accusation solely in his official capacity as the Executive Director of the Medical Board of California (Board).

2. On April 28, 2000, the Board issued Physician's and Surgeon's Certificate Number A 71464 to Farhad Bagha Nowzari, M.D. (Respondent). That license was in full force and effect at all times relevant to the charges brought herein and will expire on September 30, 2023, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise

indicated.

4. Section 2004 of the Code states:

The board shall have the responsibility for the following:

(a) The enforcement of the disciplinary and criminal provisions of the Medical Practice Act.

(b) The administration and hearing of disciplinary actions.

(c) Carrying out disciplinary actions appropriate to findings made by a panel or an administrative law judge.

(d) Suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions.

(e) Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board.

(f) Approving undergraduate and graduate medical education programs.

(g) Approving clinical clerkship and special programs and hospitals for the programs in subdivision (f).

(h) Issuing licenses and certificates under the board's jurisdiction.

(i) Administering the board's continuing medical education program.

5. Section 2220 of the Code states:

Except as otherwise provided by law, the board may take action against all persons guilty of violating this chapter. The board shall enforce and administer this article as to physician and surgeon certificate holders, including those who hold certificates that do not permit them to practice medicine, such as, but not limited to, retired, inactive, or disabled status certificate holders, and the board shall have all the powers granted in this chapter for these purposes including, but not limited to:

(a) Investigating complaints from the public, from other licensees, from health care facilities, or from the board that a physician and surgeon may be guilty of unprofessional conduct. The board shall investigate the circumstances underlying a report received pursuant to Section 805 or 805.01 within 30 days to determine if an interim suspension order or temporary restraining order should be issued. The board shall otherwise provide timely disposition of the reports received pursuant to Section 805 and Section 805.01.

(b) Investigating the circumstances of practice of any physician and surgeon where there have been any judgments, settlements, or arbitration awards requiring the physician and surgeon or his or her professional liability insurer to pay an amount in damages in excess of a cumulative total of thirty thousand dollars ($30,000) with respect to any claim that injury or damage was proximately caused by the physician's and surgeon's error, negligence, or omission.

(c) Investigating the nature and causes of injuries from cases which shall be

reported of a high number of judgments, settlements, or arbitration awards against a physician and surgeon.

6. Section 2227 of the Code states:

(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:

(1) Have his or her license revoked upon order of the board.

(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1.

7. Section 2228 of the Code states:

The authority of the board or the California Board of Podiatric Medicine to discipline a licensee by placing him or her on probation includes, but is not limited to, the following:

(a) Requiring the licensee to obtain additional professional training and to pass an examination upon the completion of the training. The examination may be written or oral, or both, and may be a practical or clinical examination, or both, at the option of the board or the administrative law judge.

(b) Requiring the licensee to submit to a complete diagnostic examination by one or more physicians and surgeons appointed by the board. If an examination is ordered, the board shall receive and consider any other report of a complete diagnostic examination given by one or more physicians and surgeons of the licensee's choice.

(c) Restricting or limiting the extent, scope, or type of practice of the licensee, including requiring notice to applicable patients that the licensee is unable to perform the indicated treatment, where appropriate.

(d) Providing the option of alternative community service in cases other than

violations relating to quality of care.

STATUTORY PROVISIONS

8. Section 2234 of the Code, states:

> The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:
>
> ...
>
> (c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.
>
> (1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.
>
> (2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.
>
> ...

FACTUAL ALLEGATIONS

Patient No. 1[1]

9. Patient No. 1 (or "Patient") was an 86-year-old male with a history of prostate cancer.

10. On June 12, 2017, Patient No. 1 was brought by ambulance from a skilled nursing facility to the Emergency Department (ED) with complaints of chest pain, feeling ill, and weakness. En route to the ED, the Patient received nitroglycerin[2] which reduced his chest pain.

11. At the ED, the Patient was noted to have lactic acidosis[3] and leukocytosis[4] consistent

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[1] Patients herein are identified by numbers to protect their privacy.

[2] Nitroglycerin is a vasodilator; a medicine that opens blood vessels to improve blood flow.

[3] Lactic acidosis occurs when the body produces too much lactic acid and cannot metabolize it quickly enough. The condition can be a medical emergency.

[4] Leukocytosis is the broad term for an elevated white blood cell count.

with possible Systemic Inflammatory Response Syndrome.[5] The Patient's renal function was normal and his vital signs were stable. The Patient's urine was noted to be "dark brownish" with a "small amount of blood in his diaper." Intravenous antibiotics were administered. A CT scan showed a mass at the base of the bladder with a blood clot consistent with probable prostate cancer invasion, no hydronephrosis,[6] and widespread osseous metastases.[7] The Patient's Prostate-Specific Antigen (PSA) test[8] was extremely elevated.

12. On June 13, 2017, Respondent was called for a consult for "intermittent tea colored urine" and the presence of a bladder mass revealed on a CT scan image. Respondent recommended cystoscopy[9] with possible transurethral resection of the bladder mass.[10] The procedures were planned for June 15, 2017.

13. The patient was consented for "Cystoscopy, possible biopsy and fulguration,[11] possible transurethral resection of bladder tumor, [and] possible transurethral resection of prostate." A hematology oncology consult was obtained which provided additional history; a diagnosis of prostate cancer in 2004 treated with radiation with subsequent recurrence treated with hormone therapy. It was also noted that the Patient lost between 25 and 30 pounds during the June 2017 hospital admission. The Patient also complained of pain in the right arm and right leg.

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[5] Systemic inflammatory response syndrome (SIRS) is an exaggerated defense response of the body to a noxious stressor (infection, trauma, surgery, acute inflammation,

[6] The swelling of a kidney due to a build-up of urine. It occurs when urine cannot drain from the kidney to the bladder due to a blockage or obstruction.

[7] A category of cancer metastases that results from primary tumor invasion to bone.

[8] A laboratory test that measures the amount of prostate-specific antigen (PSA) found in the blood.

[9] A cystoscopy is a procedure to look inside the bladder by way of a thin camera.

[10] A transurethral resection is often used to diagnose bladder cancer and to determine whether the cancer has spread into the muscle layer of the bladder wall. The procedure is performed by inserting a scope into the bladder via the urethra. The scope is equipped with an attachment used to remove any abnormal tissue.

[11] A procedure that uses heat from an electric current to destroy abnormal tissue.

14. On June 15, 2017, Patient No. 1 was taken to the operating room where a bladder mass was noted. According to the medical records, the "ureteral orifices [("UOs")] were unable to be visualized due to the mass." Tracer dyes were not introduced to aid in the identification of the UOs. The mass was partially resected. Respondent instilled formalin[12] as bleeding could not be controlled. A cystogram to exclude perforation of the bladder or ureteral reflux was not done prior to the procedure. A 3-way Foley catheter[13] was inserted, and continuous bladder irrigation was initiated and noted to be clear. Pathology revealed an advanced-stage cancerous tumor in the Patient's prostate.

15. Post-operatively, the Patient went into acute renal failure and his creatinine[14] level rose significantly. The Foley catheter was removed. A bladder scan showed no urine in the bladder.

16. On June 17, 2017, at 10:49 a.m., a renal ultrasound was obtained which showed that the Patient's right kidney was swollen. Patient No. 1 remained anuric. Respondent was notified that the Patient had not voided since the Foley catheter was removed. A Foley catheter was again placed; upon insertion, only a minimal amount of urine was obtained.

17. On June 17, 2017, at 6:52 p.m., a brain CT scan was ordered to evaluate the Patient's confusion.

18. On June 17, 2017, at 8:05 p.m., Patient No. 1 was found to be unresponsive and was pronounced dead at 9:33 p.m.

Medical Issue No. 1
Substandard Surgical Technique

19. Respondent made no effort to locate the UOs and likely obstructed them with resection. Respondent failed to obtain a cystogram prior to instilling formalin into the bladder.

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[12] Formalin coagulates the bleeding in the bladder. Prior to instillation, reflux into the ureters must be assessed with cystography.

[13] A large indwelling urinary catheter which has three separate tubes for inflating a balloon which retains the catheter in the bladder, urine drainage, and irrigation. The catheter simultaneously allows fluid to run into and drain out of the bladder.

[14] Creatinine is a waste product produced by muscles from the breakdown of creatine. Creatinine is removed from the body by the kidney.

20. Standard of Care. During endoscopic resection of a bladder mass involving the trigone, the first and most important maneuver prior to surgery is to attempt to identify the UOs to prevent damage that could cause obstruction and renal failure.

21. Deviation from the Standard of Care. Patient No. 1 presented with straightforward locally advanced prostate cancer with mild hematuria and normal renal function. It is questionable whether the patient needed to go to the operating room. During surgery, a simple departure, and an extreme departure from the standard of care occurred including failure to try to identify the ureteral orifices and the use of formalin as a primary treatment without a cystogram, respectively. These ill-advised maneuvers resulted in the development of acute renal failure and patient death.

Medical Issue No. 2
Substandard Decision Making – Improper Instillation of Formalin

22. Standard of Care. Severe bleeding from a bladder or invasive prostate tumor can be dealt with in a variety of methods, each of which is associated with a different degree of risk, invasiveness, and efficacy. Initial strategies may include: 1) Cessation of aspirin or other blood thinners (if present); 2) Continuous bladder irrigation with saline via a large bore 3-way hematuria catheter; 3) Bedside intravesical irrigation; 4) Transurethral resection of the tumor with cautery/fulguration; 5) Selective embolization by an Interventional Radiologist of the hypogastric, prostatic, vesical arteries; 6) Placement of bilateral percutaneous nephrostomy tubes; 7) Instillation of intravesical formalin.

23. Deviation from the Standard of Care. The use of intravesical formalin should only be done as a last resort and is not indicated as a primary treatment of mild hematuria. Typically, this intervention would be reserved for a terminal patient who has failed all other methods to control intractable gross hematuria. The decision to use formalin, particularly without a cystogram, represents an extreme departure from the standard of care.

Medical Issue No. 3
Substandard Decision Making – Failure to Obtain Informed Consent

24. Standard of Care. Informed consent for surgery should include a detailed discussion of all proposed procedures and their risks. The addition of procedures not included in the consent

should only be done if unexpected or deemed emergent.

25. Deviation from the Standard of Care. Respondent's informed consent for surgery did not include the instillation of Formalin.

Medical Issue No. 4
Lack of Recognition of a Complication and
Failure to Offer Potentially Life-Saving Intervention

26. Standard of Care. A work-up of a patient who cannot produce normal amounts of urine after transurethral resection of a bladder-base tumor, especially in a case where the ureteral orifices were not identified and intravesical formalin was given, should include: 1) physically evaluating the patient and including a physical exam; 2) catheter irrigation (not removal); and 3) prompt renal ultrasound or other imaging.

27. Deviation from the Standard of Care. Respondent failed to evaluate the Patient who rapidly progressed to acute renal failure after operative intervention. This is an extreme departure from the standard of care. The patient should have been seen by the urologist to determine the cause of the urinary tract dysfunction, which almost certainly was a result of the recent operation.

Patient No. 2

28. Patient No. 2 (or "Patient") was an 83-year-old male who underwent an elective ureteral stent change by Respondent on November 6, 2017.

29. Patient No. 2 had a history of a prostate cancer and an irregular heartbeat that was treated with a blood thinner medication.

30. Patient No. 2 also had a history of bilateral stent placement. On August 29, 2016, the Patient had a bilateral ureteral stent placement. On December 29, 2016, Respondent performed a left ureteral stent exchange. The indication for the chronic stent requirement or a detailed preoperative history is not contained in the medical records.

31. During the stent change performed by Respondent on November 6, 2017, a bladder X-ray showed kidney swelling. Respondent elected to perform semi-rigid and flexible ureteroscopy. The semi-rigid ureteroscope was advanced to the upper end of each ureter.

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32. Post-operatively, the Patient's blood pressure dropped and he experienced an irregular heartbeat, which required cardioversion.[15] A CT scan showed a large pooling of blood in the perinephric space[16] and retroperitoneal area.[17] Despite multiple transfusions and ICU interventions, Patient No. 2 died shortly after this routine operation.

Medical Issue No. 5
The Occurrence of a Perinephric Hematoma after Diagnostic Ureteroscopy

33. Standard of Care. Ureteroscopy at the time of routine ureteral stent change is generally unnecessary unless the urologist feels reassessment of ureteral stricture disease or abnormal fluoroscopic findings on retrograde pyelogram need prompt further evaluation. Perinephric hematoma following ureteroscopy or stent exchange is an exceedingly rare iatrogenic complication which could conceivably occur in the setting of semi-rigid ureteroscopic trauma, guidewire trauma, or possibly removal of a retained encrusted stent which had been indwelling for too long.

34. Deviation from the Standard of Care. A perinephric hematoma following ureteroscopy with stent exchange is a rare and severe event. This likely occurred from traumatic semi-rigid ureteroscopy which may not have been indicated and/or performed improperly. This represents a simple departure from the standard of care.

Patient No. 3

35. Patient No. 3 (or "Patient") was a 75-year-old quadriplegic female with a chronic indwelling Foley catheter. The Patient was previously admitted to the ED on May 29, 2017, with a urinary tract infection.

36. Patient No. 3 presented to the ED on June 24, 2017, with an altered mental status due to suspected urosepsis. While at home, a caregiver observed that the Patient's catheter was

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[15] A medical procedure that restores a normal heart rhythm that is usually performed by sending electric shocks to the heart through electrodes placed on the chest.

[16] The cone-shaped compartment within the abdomen that contains the kidney.

[17] The area in the back of the abdomen behind the peritoneum, the tissue that lines the abdominal wall and covers most of the organs in the abdomen.

twisted and noticed foul-smelling urine emanating from the catheter. The Patient was noted to have a low blood pressure of 86/42, a low sodium blood level, and had an increased white blood cell count. Initial urine studies were consistent with an infection related to the chronic catheter.

37. On July 1, 2017, a CT scan revealed a left distal ureteral stone, moderate left-sided kidney swelling, and bladder stones.

38. On July 2, 2017, interventional radiology placed a left percutaneous nephrostomy tube.[18]

39. On July 3, 2017, a hip x-ray revealed a right hip fracture.

40. On July 5, 2017, Respondent performed ureteroscopy with laser lithotripsy[19] despite the Patient's hip fracture.

41. On July 9, 2017, Patient No. 3 became unresponsive and exhibited difficulty breathing, was intubated, and transferred to the ICU. Patient No. 3 subsequently experienced acute renal failure.

42. On July 11, 2017, nephrology was consulted, and dialysis was initiated to treat acidosis.

43. Patient No. 3 subsequently decompensated into multisystem organ failure and died.

Medical Issue No. 6
Performing Lithotripsy and Use of Instrumentation without Proper Treatment of Infection

44. Standard of Care. Urosepsis due to an obstructing stone should be immediately treated with either a percutaneous nephrostomy tube or ureteral stent. Cases of complicated pyelonephritis (a form of kidney infection), especially one that presented with sepsis, should be treated, and cleared with culture specific antibiotics for 7-14 days before definitive treatment of the stone is undertaken. A sterile urine culture should be documented prior to instrumentation of the urinary tract prior to avoid sepsis.

45. Deviation from the Standard of Care. Endourologic treatment of a ureteral stone in a

[18] A small, flexible rubber tube (catheter) inserted through the skin into the kidney to drain urine.

[19] A procedure that uses a laser to break down stones in the kidney, gallbladder, or ureters.

patient with incompletely treated urosepsis who was already decompressed with a nephrostomy tube is contraindicated and represents a simple departure from the standard of care.

Medical Issue No. 7

Positioning a Patient with a Hip Facture in Low-Lithotomy[20] for Stone Removal

46. Standard of Care. Elective operative intervention which requires the patient to be in low-lithotomy position should be delayed when the patient has a hip fracture. Worsening of the fracture could lead to avascular necrosis.[21]

47. Deviation from the Standard of Care. Placing a patient in low-lithotomy position with a recent femoral neck fracture is contraindicated for an elective procedure – this represents a simple departure from the standard of care.

CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

48. Respondent Farhad Bagha Nowzari, M.D. is subject to disciplinary action under section 2234, subdivision (c)(1) and (2) of the Code, in that he committed multiple acts of negligence in the care and treatment of Patients 1, 2, and 3. The facts set forth in paragraphs 9 through 47, above, are incorporated by reference as if set forth in full herein.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 71464, issued to Respondent;

2. Revoking, suspending or denying approval of Respondent's authority to supervise physician assistants and advanced practice nurses;

3. Ordering Respondent, if placed on probation, to pay the Board the costs of probation monitoring; and

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[20] Lying on the back with legs flexed 90 degrees at the hips. The position is named for its connection with lithotomy, a procedure to remove bladder stones.

[21] Death of bone tissue due to a lack of blood supply.

4. Taking such other and further action as deemed necessary and proper.

DATED: SEP 09 2021

WILLIAM PRASIFKA
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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